Monroe County Employee's
SPECTERA VISION CARE
REIMBURSEMENT REQUEST FORM
FOR OUT OF NETWORK SERVICES ONLY FOR EMPLOYEES NOT MEETING ACCESS

PART I - EMPLOYEE DATA

Employee's Name	Social Security #		
Address	**City**	**State**	**Zip Code**
Patient's Name	**Patient's Date of Birth**		
Relationship To Employee	**Date**		

PART II - REQUEST

To obtain reimbursement, complete this form and submit this with your itemized bill and paid re

SPECTERA CLAIMS DEPARTMENT
P.O. BOX 26618
BALTIMORE, MD 21207-6618

I hereby request reimbursement for up to the following:

☐	$60.00 Eye Exam	☐	$60.00 Single Lenses
☐	$75.00 Frames	☐	$80.00 Bifocal Lenses
☐	$240.00 Contact Lenses (Necessary)	☐	$100.00 Trifocal Lenses
☐	$125.00 Contact Lenses (Elective)	☐	$100.00 Lenticular Lenses

e: Receipts must be submitted <u>together</u> for services or materials purchased on different da
› receive reimbursement. Attach an itemized statement and paid receipt for your expenses.
A separate claim form must be submitted for each patient.
Contact lens reimbursements are in lieu of eyeglass lenses and frames.

Employee's Signature _____ Date _____

Spectera Customer Service: 1-800-638-3120